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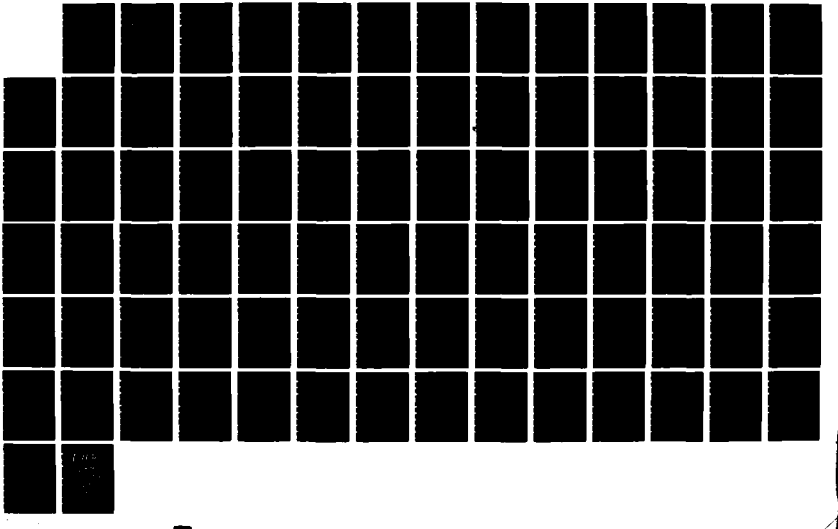

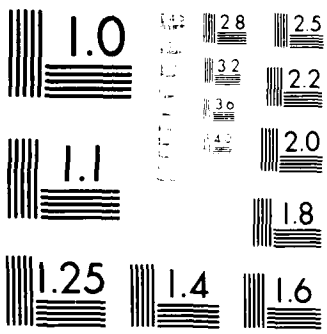

A STUDY TO ASCERTAIN THE FEASIBILITY OF JOINT EFFORTS TO ESTABLISH A COMPREHENSIVE HEALTH CARE DELIVERY SYSTEM UTILIZING HILL-BURTON CONSTRUCTED HOSPITAL

by

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Utilizing a financially distressed acute care hospital, this paper attempts to demonstrate the effectiveness of developing a coalition which can restructure the acute care hospital into a successful community-based comprehensive health care delivery system.

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I INTRODUCTION

Background

This nation, for the past 31 years, has witnessed both the achievement of the explicit goals of the Hospital Survey and Construction Act and concurrent vocal and valid criticism of the results of this legislative mandate. The Hill-Burton Program, as it is commonly known, was born following a period in our nation's history which was signified by economic depression and World War II. Capital expenditures on hospitals were limited if marginally existent due to the economic impact and contingencies of the time.

Following World War II it was generally acknowledged that existing medical facilities were obsolete, drastic shortages of inpatient hospital beds prevailed, and those existing beds were badly distributed both within and among the states.[1] The Hill-Burton Program (Public Law 79-725) challenged these important national issues. Through Congressional legislative action, subsequent amendments, and complimentary public laws, the explicit goals of the Hill-Burton Program have been reached. New hospital construction and modernization has flourished to the point where health care advocates, and indeed even the public consumer, admonish the health care industry as being an overbedded, financially inefficient system that propels ever rising costs. Increased costs cannot individually be associated with excessive hospital construction. Too many other factors in our economic system deserve equal attention. Nevertheless, excessive construction and overinvestment in hospitals generates not only the high visibility of poor

planning, but predictably places many federally constructed hospitals in precarious financial positions, some boarding on loan default, others bankruptcy receivership.[2] It has also had a significant impact on the comp. puzzle or rising health care costs.

The concept of forced closures of hospitals, once nonexistent in the lexicon of health care proponents, is now evident in the current literature of our day. Transitional allowances to assist facilities in closing down or converting hospital beds where they are no longer needed has been voiced by Senator Russell B. Long (D-La.), chairman of the Senate Finance Committee, the most active forum on hospital financial matters.[3] Public Law 93-641 also implies that reverse certificate of need activities are on the horizon, instituted by local health service agencies against unneeded and inefficient hospitals due to an over-investment in plan resources.

Macro observations of the nation's overbedded circumstances becomes evident when trend rates are compared over a period of time. The nation's average bed occupancy rate is down from a high of 84.6 percent in 1960 to 76 percent for calendar year 1976.[4] Further, a study conducted by the American Hospital Association indicated that 20 percent of inpatients in our nations hospitals need not have been admitted in the first place, but rather treatment could have been rendered in an ambulatory care environment had it not been for existing

third party medical payment mechanisms.[5]

At the micro level, each one of those unused hospital beds affects the financial position of a hospital and also contributes to rising health care costs. In 1975, the Cost of Living Council estimated that it cost the typical acute care general hospital about 60 percent as much to maintain an unused hospital bed as an occupied one.[6] Each unoccupied hospital bed compounds the problem of spiraling costs. The primary source of revenue for a hospital is generated from inpatient occupancy. Vacant beds and the resulting loss in revenue must be made up somehow and the course of action results in increase charges of existing patients. From an economic standpoint, no business can continue to survive in the long run with a negative cash flow. To exist and survive the community pays the price for vacant beds through increased charges.

The subject of hospital financial difficulties or failures becomes even more complex and intriguing when crises arise in institutions whose very existence bears the imprimatur of the Federal government. Many hospitals have undergone an extensive construction program financed wholely or in part through the Federal government's grant and loan programs. Any hospital constructed under these programs undergo extensive review in determination of community needs.

However, times change and problems develop which were not foreseen in the early planning and review processes. Community demographics markedly change, major employers depart, physicians age, retire, and recruitment is non-productive. On the other hand, communities grow, provider competitors appear, challenges are made on hospitals in the form of status of technology, elite physician compliments, and increased specialization of labor which constantly chips away at declining revenue margins. Concurrently, ambulatory care dramatically increases, inpatient occupancy declines and the hospital is threatened by newer, more modern hospital competitors.

Either scenario could be extended to serve the perspective intended, but the results remain the same. The government, as attested by its original grant and loan activity, has an investment in the health care needs of communities so described. Its investment is both moral and financial for the promotion of health, locally and nationally. What positive actions can be taken? What initiatives can be provided whereby selected community hospital, constructed with Federal funds, can survive the threats of extinction and continue to provide medically needed services in an economical manner?

Conditions Which Prompted the Study

Since its inception, the Hill-Burton Program has generated almost $4 billion for hospital construction, and by recent estimates, the

program has created about 60,000 surplus beds.[7] Of this $4 billion, $1.5 billion is directly attributed to federal loans or loan guarantees, which must be repaid with interest.[8] Regardless whether the construction or modernization funds were in the grant or loan category, the implicit relationship between the Hill-Burton Program concept and the ultimate creation of new and modern hospitals was that of need. The federal government was in fact investing in a documented community need for health care and hospital beds. However, whatever goals established in 1946 for the Hill-Burton Program are but retrospective comments in 1977. Evolving economic, social, and financial environments are benchmarks of changing times.

It is interesting to pause and reflect on constrasting elements of the health care industry over this period of time. Hospital operations and construction are now marginally subsidized by philanthropy. Third party reimbursement is now the dominant source of hospital revenue with cost based formula which make it difficult for hospitals to make a profit. Stiff government controls at both the Federal and State levels impose restrictions on hospital operations such as rate review commissions, PSRO agencies, price controls of the early 1970's, and present debates in Congress regarding restrictive revenue requirements or 'CAP' actions which are on the legislative horizon. Formulation of the objectives of health legislation in 1946 did not envision the

complexities of the 1970's.

Amid this plethora of complexities, the Division of Facilities Development, an agency of the Bureau of Health Planning and Resources Development, Department of Health, Education, and Welfare, (DHEW), is charged with administering, monitoring, and providing technical assistance to hospitals utilizing Federal loan funds for construction or modernization purposes. The Division of Facilities Development is assisted in its efforts by field personnel, on-site, in ten DHEW regions.

On February 24, 1977, a meeting of the Loan Advisory Board, Division of Facilities Development, was held in the Hotel Continental, Kansas City, Missouri.[9] In addition to representatives of the central office, five regional representatives were present. The agenda for the meeting consisted of a joint problem solving session regarding significant and critical management areas in the administration of the loan program. Case analysis of hospitals in significant financial difficulty were discussed in detail. Emphasis during this meeting was primarily directed at technical and financial loan defaults. Sufficient evidence was presented that clearly indicated that a systematic and coordinated approach be taken by the division to insure better surveillance of actual or potential hospital loan failures,

recognition of impending problems, and subsequent recommendations to resolve problems associated with both the awarding and/or administration of Federal loans. The minutes of this meeting were distributed and became a matter of record.

In retrospect, it is difficult to discern how the results of this meeting were identified by another Federal agency, let alone one prepared to capitalize on this opportunity such as the Division of Health Maintenance Organizations. This agency suggested that a demonstration of government support, utilizing an HMO-like foundation, could provide potential solutions to the financial predicaments reported of some federally constructed hospitals.[10]

The Division of Health Maintenance Organizations (DHMO) is a relative youngster amid the myriad of other Federal programs operating today. Mandated by Public Law 93-222, this division of the Office of the Assistant Secretary for Health, DHEW, administers a grant and loan program for developing health maintenance organizations throughout the nation. The HMO Act, signed by President Nixon in 1973, authorized federal involvement in the planning and initial financial support of a unique delivery system of individual and family health care which has great potential for improved health status and resource utilization in the United States. Historical background information, general characteristics, advantages, and disadvantages of HMO infusion into the health

industry are not appropriate for this space and will be developed later. Suffice to say that the HMO Division of the Department of Health, Education, and Welfare is a futuristic, forward looking agency of the Federal government, charged with the President's personal instructions to stimulate development of HMO's nationally. By 1976, President Nixon wanted 1700 HMO's with 40 million members across the country.[11]

The HMO Division, was primarily created to reduce health care costs while simultanously providing comprehensive health care services to the population at-large. Upon review of the loan problems of hospitals, the HMO Division noted the impact of medically unneeded acute care beds resulting from the geographic overbedded hospital construction projects funded by past Hill-Burton Programs. The HMO Division recognized the increased financial problems of rural, federally constructed hospitals. Frequently, hospitals in this category predicted loan defaults and possible closures. Opportunities appeared to exist to demonstrate the advantages of innovative approaches whereby existing community resources could be utilized in the development of a community based comprehensive prepaid health care system. If required, federal demonstration programs, utilizing grant monies, could be instituted to salvage financially depressed medical facilities until sufficient community involvement was elicited to initiate the prepaid concept.

Further studies needed to be conducted regarding the possibility of such a program.

Statement of the Problem

To develop a program to demonstrate the effectiveness of concerted Division of Health Maintenance Organization and Division of Facilities Development actions to involve financially distressed Hill-Burton hospitals, the professional community, business and industrial entities, and the community as a whole in the development of a successful community-based comprehensive health care delivery system.

Objectives

The objectives of the study are:

1. To identify a financially distressed acute care hospital, constructed and equipped with federal funds, that would be appropriate for HMO intervention.
2. To determine alternatives and innovative methods of improving the financial posture of such a hospital, thus salvaging the significant investment the government has made in the medical needs of a community.
3. To review and compare barriers to the development of hospital based HMO-like organizations.

4. To determine if the advantageous characteristics of HMO-like organizations can be successfully instituted in a hospital based operation.

Limitations

Limitations of this study are as follows:

1. Financial and administrative constraints will limit personal travel for investigation.
2. Metropolitan acute care general hospitals will not be considered.

Assumptions

The following assumptions are made in preparation of this study:

1. Both the Division of Health Maintenance Organizations and the Division of Facilities Development will continue to be viable entities within the Department of Health, Education, and Welfare.
2. Utilization Review, PSRO, and HMO concepts will continue to reduce inpatient bed utilization factors, thus proliferating the surplus bed situation.
3. Demand for inpatient care will not increase as a result of formulation of national health insurance.
4. Passage of legislation requiring restrictive revenue regulations can be waived for financial distressed hospitals.

Research Methodology

Information obtained for this study will be acquired utilizing several methods:

1. Review of literature related to the history of major capital investment in hospitals by the government, e.g. Hill-Burton Act, Comprehensive Health Planning Act, Regional Medical Program, Housing and Urban Development Act, Farmers' Home Administration Program, and P.L. 93-641.
2. Literature review related to prepaid group practice and HMO's.
3. Literature review regarding hospital based physician practices, chronic or long term care as a hospital inpatient service, hospital utilization trends, and negative revenue center improvements.
4. Unstructured interviews with central office and regional representatives of the Public Health Service responsible for hospital construction and development of health care delivery systems.
5. Unstructured interviews with hospital administrators and physicians of hospitals threatened with financial crisis.

Review of the Literature

Information in abundance exists regarding health maintenance organizations and prepaid group practices. Evaluation of HMO development successes are plentiful, however, individual organizational failures are not widely reported. Hospital based HMO practices are limited to large, established and successful corporate efforts

associated with large capital resources. Limited material exists on small, rural hospital based HMO development.

Periodicals, books, government publications, and public laws all contain information relating to HMO operations and concepts which will assist this author.

Resource material for HMOs are found in volumes. HMO developmental processes are detailed by authors such as Kress and Singer,[12] Birnbaum,[13] L. Goldberg and M. Greenberg,[14] I. Greenberg,[15] Roemer,[16] and Prussin.[17] Marketing of HMOs is discussed by Burke,[18] Lewis,[19] and Biblo.[20]

Hill-Burton Program, its historical development and impact on health care nationally are discussed by authors J. Lave and L. Lave.[21] Reference material pertaining to difficult financial conditions of some hospitals has been discussed by Ellwood,[22] Kernaghau,[23] Rogatz,[24] Johnson,[25] and Wasyluka.[26]

Specific care studies and unpublished information is contained in government files which will also privide this author with sufficient reference material to pursue this study.

Footnotes

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8. Interview with Mr. R. Inhenta, Budget Review Branch, Division of Facilities Development, Bureau of Health Resources Administration, Public Health Service, Department of Health, Education and Welfare; Hyattsville, Maryland (26 September 1977).

9. Memorandum prepared for the Acting Director, Division of Facilities Development, by Mr. Louis Gittleman (27 February 1977).

10. Meeting attended on 28 September 1977, between Mr. Sam Gilmer, Division of Facilities Development and representatives of the Division of Health Maintenance Organizations; Hyattsville, Maryland.

11. Remarks by Under Secretary of Health, Education and Welfare, Mr. Hale Champion, before the Group Health Association of America, Bonaventure Hotel, Los Angeles, California (20 June 1977).

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II BACKGROUND AND HISTORY

Hill-Burton Program

The Hospital Survey and Construction Act of 1946, popularly known as the Hill-Burton Program was created by an Act of Congress to survey the needs of communities for various kinds of health care facilities and to develop State plans for the construction of public and voluntary nonprofit hospitals, public health centers, mental hospitals, and chronic disease hospitals. The visibility of the program was dramatized through a system of financial grants for actual construction and necessary operating equipment. The Program was broadened in 1954 to include voluntary nonprofit nursing homes, diagnostic and treatment centers, and rehabilitation facilities. In 1964, the Program was further expanded to permit grants for the modernization or replacement of previously constructed health facilities.

Housing and Urban Development Act

As a complimentary measure to increased public expenditures, the federal government initiated action to attract private capital for financing hospitals and related care facilities. In 1968, the Housing and Urban Development Act was mandated by Public Law 90-448. Title XV of this Act provided that HUD's Federal Housing Administration established a program of hospital morgage insurance for construction or modernization of hospitals. This legislative action recognized that public financing mechanisms were insufficient to meet the needs of construction and modernization. In a memorandum of aggreement

signed in 1969, the Department of Housing and Urban Development and the Department of Health, Education, and Welfare established joint responsibility for administration of the FHA morgage insurance program for hospitals.

Hill-Burton Amended

As a supplement to grant legislation, Congress amended the Hill-Burton Program in 1970 to allow direct loans and loan guarantees for the construction and modernization of hospitals and related health care facilities. This particular amendment, Public Law 91-296, permitted loan guarantees to private hospitals for the first time under expanding roles of the Hill-Burton Program and affected a federal subsidy to lower the cost of borrowing for approved applicants.

Public Law 93-641

To bring this synopsis of hospital construction and modernization to date, a brief identification of the National Health Planning and Resources Development Act of 1974 is also necessary. Public Law 93-641, as it is commonly identified, revised the former Hill-Burton Program. PL 93-641 now assumes full responsibility for providing assistance through grants, loans, and loan guarantees to projects for modernizing, new construction, or the conversion of existing medical facilities to provide new health services. The essence of this

comprehensive law rests on community level planning for health services. This act combined and redirected the efforts of Federally supported programs to State and local agencies that perform health planning and resource development for their communities. The objective of the Act was to improve the health status of the American people through a planned orderly approach to the needs of individual communities by removing barriers to development, eliminating duplication and waste, and providing technical and financial assistance in a coordinated approach to the problems of the nations' health system.

Hill-Burton Past and Present

The Hill-Burton Act provided substantial funds for hospital construction to remedy the shortage and maldistribution created by the lack of hospital development which failed to occur during the Depression and World War II. The Act, from 1942 to 1964, greatly alleviated this shortage of hospitals and hospital beds by providing not only for grants for acute care construction, but also for the construction of chronic disease hospitals, rehabilitation facilities, and nursing homes. In 1964, amendments to the Act provided funds not only for additional construction, but also for modernization and replacement of existing facilities.

During the period 1947 to 1974, over $4.1 billion in grant funds were appropriated for construction or modernization and in excess of

$1 billion in loan principle was committed throughout the United States. During this same period, a total of 11,493 grants were approved, accounting for an increase of 496,000 beds.[1] In this capacity, the Act had aided 4000 communities in the modernization or construction of over 6500 public and non-profit medical facilities.

With the enactment of amendments to the original Public Law, the year 1970 saw a reversal from public grant funds to emphasis on loans and loan guarantees. Between 1972 and 1974 loans accounted for the development of 255 projects valued at $97.7 million in direct federal loans.[2] However, the significance of this switch from grants to loans coincides with a drastic reduction in the development of new hospital beds. Only 3 percent of the funds loaned went to new bed construction as opposed to 78 percent in earlier years. The deemphasis in new hospital construction as seen at the end of 1974 was directly related to the knowledge that the nation was becoming rapidly over-bedded and hospitals were projecting increasingly low bed occupancy rates. Data developed by planners indicated that in early 1975, 40,000 surplus beds existed in the United States. Although the Hill-Burton program achieved its goal to alleviate the maldistribution of hospital beds in the nation, it had played a significant role in the creation of a drastic bed surplus thus contributing to a rise in unnecessary costs. This rapid increase in health care costs gave rise to the enactment

of Public Law 93-641 which absorbed the Hill-Burton Program and created agencies and actions designated to not only control and channel new construction, but to encourage closures or mergers of those facilities considered superfluous to the community. No longer was the emphasis to be placed on the creation of facilities. Health manpower and environmental factors were to be combined with the need for facilities and service into a planned effort for a community ranging in size from 500,000 to 3,000,000 in population. This area, under P.L. 93-641, is titled a Health Service Area (HSA).

These HSA's are federally funded for the hiring of staff for the development of local plans to meet the needs of the population served. Part of their responsibilities consist of reviewing all proposals for the addition of new beds in the community or any substantial change in service at the local level. As a deciding factor, $100,000 was the determining amount that required review by the HSA. At the State level, P.L. 93-641 created the State Health Planning and Development Agencies which reviews a State Medical Facilities Plan that outlines how federal funds are to be spent on the construction or modernization of hospitals.

The National Health Planning and Resource Development Act, P.L. 93-641, essentially brought the Hill-Burton program under the State Health Planning and Development Agency for operational control.

Projects described in the State Medical Facilities Plan are to be reviewed by the appropriate local HSA and then approved by the State Agencies. Hill-Burton was no longer a federal instituion. The hugh staff formed to manage the expenditure of funds and to determine the physical construction needs of a service area were dramatically reduced. State and HSA plans were now to conform to national health policy and the rising cost of health care was and is today a major factor. Under P.L. 93-641, total funds allocated for new hospital construction or modernization have been dramatically less than dollars spent in the years of the Hill-Burton Program. Interest free government grants for modernization or construction of community hospitals have essentially been replaced by commercial or government loans. Repayment of this interest and principle is a financial obligation and expense which increases the costs of health care to all seeking services at a medical treatment facility.

Hospital Expenses

The changing and developing of new government programs and resulting laws is related to many problems associated with the health system of the United States. Over the years as our nations developed, the costs of health care have suddenly become of significant concern to both the general population and the government. The development of restrictive laws which demand review and planning such as P.L. 93-641

is indicative of government intervention in the health care system to control rising costs. The steepest of cost inflation in the health care system is to be found in hospitals. The reasons for this rapid rise is hospital expense in multifold. Although consumers and government cry out over the increased costs, few remember that hospitals and their administrators must cope with the increase expenses generating these costs. The major reasons for the starting increases in costs can be summarized as:

General Inflation: The rise in the general inflation of the nation is a contributing factor especially in the area of food, fuels, paper products, and construction.

Population Growth: A simple fact of demand and supply in the growth rate of the population.

Increased Utilization of Short-term Hospitals: Attributable factors here rest with the increased percentage of the nation's elderly who need more health services; the increased affluence of our population due to the advent of federal and commercial health insurance plans; new medical technology has increased the demand for short-term hospital evaluations of the sick; the growing specialization of doctors require the need for higher utilization of short-term hospitals; and hospital emergency rooms have become the source of primary care services as

opposed to private practice physicians.

Increased Capital and Equipment Costs: Hospitals have experienced large increases in capital and equipment costs due to the advances in medical technology and elaborate facilities now required to house their technology and the patients it serves.

Higher Personnel Costs: Increased requirements for specialized help; higher density of employees per patients; and a general rise in wages plus minimum wage laws have all had an effect on increased expenses to hospitals.

Utilization Review Procedures: The elimination of unnecessary admissions and the reduction in the length of patient stays due to Professional Standard Review Organizations and Utilizations Review Committees have produced unoccupied beds and reduced the length of patient stays in hospitals. This has had the effect of increasing the cost charged patients so that hospitals can meet their expenses.

Reduced Philanthropy: The reduction of personal and government gifts have resulted in hospitals seeking federal and commercial loans. These loans require the repayment of funds not previously an expense in many facilities, thus adding to the fixed costs of hospitals.

Lack of Incentives: Generous reimbursement mechanisms by public and private health insurers have made hospitals reluctant to resist the various elements which force rising costs. No challenges are made to the physician by the administrator for the acquisition of sophisticated and expensive equipment. The physician desires the prestige of hospital expense. As such the physician and not the administrator become the villain in this scenario of who determines the cost borne by society. Nevertheless, the ease of reimbursement on cost accrued to hospitals makes it difficult for the administrator to resist demands for such items as increases in wages or denials to physicians on their requests for new technologically advanced equipment.

The rise in hospital expenses cannot be attributed totally to only the above list of selected items. The list can be extended to include the impact of the payment mechanism wherein the consumer rarely is directly confronted with the total costs of the bill for services rendered. Insurance policies pay the bill with the consumer receiving moderate but acceptable premium rate increases. Confrontation with the consumer is avoided at the point of purchase. Frequently, the absence of co-payment on the part of the patient completely detaches the consumer from the actual price he or she pays and the total cost of medical care utilized is ignored. With third party payors, the

consumer is simply not concerned about the costs of health services. This fact has a tendency to increase demand and perpetuates the increased cost situation. Insured customers use services they did not use previously.

Government involvement and regulations are also responsible for increased expenses being borne by hospitals. Some of the major cost inflators are the minimum wage laws, OSHA and EPA qualifications, drug licensing standards, budget review, quality assurance requirements, and rate and reimbursement regulations. Federal laws are not the only culprit. State and local agencies are attributable to a multitude of elaborate legislative requirements for examining the adequacy of community hospitals and services. All to frequently, these agencies and regulatory bodies fail to coordinate legislation among themselves thus often duplicating unnecessary evaluations of the health services and adding unnecessarily to the expenses borne by hospitals.

Government involvement in the operations of hospitals requires these facilities to recover revenues to meet these expenses. But these elements of the cost/expense problem are rooted in a foundation of poor planning. Increased costs which can be attributed to significant increases in health benefits or outcomes are an exceptable expense in our society. Those costs that are not viewed as a positive function are subject to serious question.

History clearly reveals that an absence of planning during the Hill-Burton boom days resulted in the generation of excess capacity through the subsidization of new hospital construction. This excess capacity is measured in vacant unoccupied hospital beds which, it is estimated, costs a full two-thirds to operate as an occupied bed. These unoccupied bed costs are passed on to the consumer of all health services and subsequently the principle third-party payor who pays the bill as insurers. This increased costs to the federal and state governments has been spectacular. Some numbers are chilling. From 1965 to 1977, the nations total expenditures on health rose from $39 billion to $160 billion. At present, 12.5 cents of every federal dollar goes to the health industry. Since 1966, health expenditures by the federal government grew from 5.9 percent of the gross national product to 8.3 percent in 1977. It has been estimated that this figure will approximate 10 percent by 1980. Hospital care is the single largest item in the nation's health care bill, approximating 40 percent of the total costs borne by tax payers. Much of this is the result of runaway excess capacity which results in excessive beds and the labor, equipment and services associated with those beds. Not only does this excess capacity cause unnecessary increased costs, it does not contribute to any benefit to health status.

Reduce Excess Capacity

This assessment of the current excess capacity of acute care hospitals in general has led to the conclusion that the associated cost could be reduced by elimination of hospitals or transference of services to more efficient operations. This position has been expressed by a number of agencies and authors. The Institute of Medicine of the National Academy of Sciences has suggested a 10 percent cut in the number of short term acute hospital beds in the nation. The Institute has gone on record by stating that significant surplus of short term beds exist or are developing in many areas of the United States and these beds are contributing significantly to rising hospital care costs. Even the national Blue Cross Association has offered as one of its suggestions the alternative of reducing capacity by simply closing hospitals who exhibit excess capacity. The cost to exact closures or partial closures has been expressed in a formula which compares the costs of closures with the costs of staying open. Interestingly, two other equations are also given in the Blue Cross Association's suggestions. As alternatives to closures, the Association offers the alternatives of conversion and consolidation. Conversion represents changing the existing physical plan to an entirely new and different configuration. Consolidation represents remaining in operation but probably at reduced levels of capacity in conjunction with other health service facilities in the immediate area. Each alternative suggested by the Blue Cross Association provided generalized

mathematical formulas wherein comparisons could be made to the total costs of remaining open. If the cost of either closure, conversion, or consolidation is less than the total costs of no change, then the redistribution of excess capacity could generally be viewed as being economically sound.

The subject of excess capacity has been the leading argument of those who believe many of our short term acute care community hospitals should close their doors. Walter McClure, writing for Interstudy, Inc, a Minnesota based think-tank, has suggested that hospital capacity in the United States could be reduced by at least 20 percent or more without harm to the health of the American people.

More and more voices can be heard exposing the theme of the validity of closing hospitals based upon their low occupancy and high fixed cost which impact on the overall total health budget. Granted, some closures are necessary. However, there are hospitals across the nation that are suffering from financial diffficulty based upon the very factors mentioned above that could be salvaged from closure if initiatives were directed at alternative methods of providing care for the communities they serve. Those hospitals whose very creation resulted from federal loans for construction are ideal targets of attention. In these projects, the federal government recognized at some period, a valid requirement for health services being provided a community.

Once financed, the interest payments on the federal loans were monitored, but the record shows that this long distance audit requirement was less than spectacular. Frequently, hospitals fall behind in interest payments to the point that third party financial institutions would contact government loan representatives regarding the government's guarantee provisions of the original loan.

With the creation of P.L. 93-641 and the subsequent demise of the vast army of Hill-Burton employees, government reorganization was essential. The Division of Facilities Development, Health Resources Administration, Department of Health, Education, and Welfare became the agency which inherited the remaining talent of a vastly reduced Hill-Burton staff. Decentralized control was instituted wherein regional officers monitored the results of government actions, activities, and loan programs across the nation. This decentralization combined with a new reorganizational effort a reduced staff gave impotence to reduced efficient and corresponding failure to monitor federally guaranteed loan programs until many hospitals were facing financial disaster, loan default, and closure.

Division of HMO Initiatives

The Health Maintenance Act was enacted in 1973 from the recognition by government that the costs of traditional methods of health care

delivery were sky rocketing and that other methods existed that, not only could redistribute resources, but could hold down the unusual rising costs in the health care field. The economics of the health industry did not function on a classical basis as found in the American market place. Incentives were the reversal of that found throughout the American economy. Incentives ran in the direction of higher cost, not lower. Little concern was given to costs based on the fact that neither the doctor nor the patient paid for services. Ninety percent of all hospital bills were paid by third parties. Fees were established for services rendered, and the fees multiplied as the services multiplied. In the health care economic model, the physician, not the consumer, made the decisions about the services rendered. In short the qualities normally associated with the market place, eg., wide distribution of services at reasonable cost, were glaringly absence. Consumer choice was largely absent, planning was scant, and competition was almost non-existent.

One method of attack on that economic system was government support to a national system of prepaid medical services or Health Maintenance Organizations. As of 1978, only 6.5 million members existed in 175 plans, far less than expected.

The agency responsible for the development of HMOs meeting federal qualifications was constantly searching for new marketing areas and

communities to increase the program which had begun from a small staff and now had the support and attention of the highest levels of government.

Over the years, very little success had been achieved in developing hospital based HMO-like organizations. Essentially, this failure was the result of the view held by most medical staffs, administrators, and professional socialites that HMOs were a threat to their survival This threat exhibited itself in reduced occupancy levels in hospitals which retarded revenue for hospitals and challenge traditional fee for service payment system associated with private practice medicine.

HMO's Basic Concept

As a method of curtailing rising health care costs and reducing the inefficiencies in the current system of delivering health care, Health Maintenance Organizations have become a much discussed mechanism by the government since the beginning of the 1970's.

HMO's take many forms, but all have certain common characteristics. Essentially, HMO's are defined as an organized system that provide a comprehensive range of health maintenance and treatment services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.[8]

In some HMO's the medical staff works on a salaried basis, performing their services in outpatient facilities and hospitals owned

by the HMO itself. This form of organized practice has lead to the nickname of "closed panel HMO's". Another popular form of HMO's is classified as IPA's or individual practice associations, wherein doctors practice in their private offices, consult with other doctors of the HMO in other private offices, and send their patients to hospitals under contract to the HMO where inpatient care is provided. Salaries are not provided physicians in individual practice associations, but rather the individual fee for service payment mechanism continues between doctor and patient at reduced rates even though the patient pays a fixed monthly premium to the HMO or its insurance carrier. It is usual that the physician in this type of HMO will continue to handle other than HMO enrollees outside the HMO in the usual fee-for-service manners.

Between these "closed panel" of HMO's and the individual practice associations described above, there is a range of HMO's, each with a system which varies in such things as capital, the degree to which facilities are owned, the payment mechanism to physicians, types of care provided, the population served, the utilization of insurance carriers, and the use and availability of trained management assistance to insure the efficiency and growth of the HMO.

As an alternative health care delivery system, HMO's have met with many solid barriers to their development. Firm opposition from insurance groups, local medical societies, and the national American Medical Association have all brought effort to bear to deter the

continued proliferation of HMO's. Physician members of HMO's have found themselves excluded from membership in state or county medical societies. This ostracism results in these doctors losing hospital privileges making it impossible to admit enrolled HMO members to inpatient facilities. It was common in some states that prepaid plans were required to have a designated percentage of HMO physicians as members of the county or the local medical society or that organization would institute restrictive sanctions against HMOs, thus barring of HMO-like organizations from further development. With the enactment of the HMO Act of 1973 and Federal Trade Commission involvement in legal action to increase competitive advantages, HMOs have witnessed a reduction in professional sanctions and an increase in growth. In 1971, 33 HMO-like organizations were operational. At the conclusion of 1973, the year of the Federal HMO-Act, 125 prepaid group practices existed in the United States.[9] In 1974, 50 more organizations became operational and the total growth as of 1978 has evolved to 200 HMOs with 6.3 million members.[10]

Prepaid Group Practice Advantages

There are inherent advantages to any HMO under the prepaid group practice concept and the emphasis is on economics. Because enrollees pay a preestablished fixed monthly payment to the HMO, there is a built-in incentive for the health provider to minimize expenses and avoid unnecessary services to the HMO member. The goal of the HMO provider consequently is to keep his patient well and cut back on services, equipment, and unnecessary facilities. Conversely, the traditional fee for service practice of medicine emphasizes that each additional

service rendered the patient creates an income producing mechanism for the doctor. In this environment, the sick person becomes increased income for the physician. In an HMO - the reverse is true.

Many studies have been conducted by government and private organizations which have proven this thesis. The fact that prepaid group physicians do adopt a prudent need for hospital admissions, keeping patients hospitalized for a relatively short stay combined with the use of maximum diagnostic workups on an outpatient basis has been discussed at length by Milton I. Roemer in an article published in 1971.[11] The Civil Service Commission, in a study conducted on federal employees, compared the number of hospital days its employees utilized services under the standard Blue Cross/Blue Shield plans versus that of its HMO enrollment. The study indicated that the traditional Blues Plan averaged 924 hospital days per 1000 persons, while the federal employees in an HMO averaged only 422 days.[12] Another interesting study comparing Medicaid members in an HMO versus those using the fee-for-service system revealed that HMO enrollees used 30 percent fewer hospital visits, 15 percent fewer physician visits, and 18 percent fewer prescription drugs.[13] One widely comparative evaluation is described below:

Doctors Visits & Hospital Days[14]

Three Different Plans

Health Plan	Doctor Visits/1000/yr	Hosp Days/1000/yr
Commercial Insurance	3104	864
Blue Cross/Blue Shield	3984	1109
HMO	3341	526

These statistics by a noted scholar on health care delivery indicate that the HMO concept offers dramatic evidence of less hospitalization for members.

HMO economics are to be found elsewhere. Routine administration, manpower utilization, proper distribution of physician specialities, and equipment utilization can efficiently be managed economically within an HMO-like organization. Reduction of duplication of staff and equipment at a centralized facility is one such benefit derived from an HMO as opposed to the traditional fee-for-service system. The emphasis on ambulatory care results in an educational program for both the HMO physician and the member. Since routine health insurance often does not cover outpatient care, the traditional patient often waits until his physician will admit him in order to cover his medical expenses through his insurance policy. In an HMO, the educational process directs the patient to use his outpatient benefits early in the illness. His monthly payments cover such care. This early treatment reduces expensive hospitalization to the HMO and, to some extent, improves the health status of the HMO member because he or she find no financial barriers to early outpatient care. Economics are reflected in the ratio of beds per member, physician per member and consequently, expenses

per member.

One advantage of HMO-like operations is the built-in requirement of internal evaluation of the medical status of the members of the HMO. This continual evaluation is of interest to the HMO so that the organization's performance can be evaluated. This performance evaluation results in detailed quantifiable statistics being kept on enrollees, physician, procedures, and costs. The results also creat close internal scrutiny of all physicians participating in the group practice. The entire concept of performance evaluations introduces established standards and goals not normally found in the traditional fee-for-service system of delivering health care.

This attention to performance from within effects the quality of medicine practiced in behalf of the HMO members. The physicians of the prepaid group practice has ready access to specialist for referral of his patient. Therefore, the physician of the HMO has no concern over a referral that may cost him a fee in the future. The HMO physician has no incentive to practice outside of his speciality. The patient benefits throughout the course of treatment as a result.

With these above advantages, the hospital and its management must look closely at both the benefits and the disadvantage inherent in the potential involvement with or functioning as an HMO. To the hospital, any attempt to reduce occupancy rate is financial suicide and this is

a goal of an HMO. Nevertheless, in a few cases, an HMO has been organized around an outpatient clinic. Steps such as these have been successful in increasing the efficiency of the clinics, improving the quality of care rendered, and actually increasing revenues by attracting a broader spectrum of patients than had been in the existing hospital before. Therefore, a hospital based HMO has significant potential providing certain requirements are met in advance or, in the absence of such requirements, action can be taken to correct certain shortfalls.

Requirements for Developing a Hospital Based HMO

When studies are conducted and published noting the barriers to development of HMO's and the reasons existing HMO's have failed, it becomes relatively apparent what is needed by a hospital or any organization to be successful in the development of a prepaid group practice. Almost all the literature agrees on some essential factors for development that must be present for the hospital to initiate HMO actions. These factors can be classified as objective and subjective, but are elements necessary for development.

One such factor always mentioned is the presence of an adequate population base. The population base in any given area is the basis upon which an estimate can be determined as to the potential size of the HMO market. For this purpose the HMO must determine favorable demographic data to include: age, sex, income, education, occupation, composition

of families, and predominant location in the area in relation to the activity of the projected HMO. All of this data on population must be used as a research window to review the potential size of the market necessary for providing an adequate enrollment when competition is considered. Within the considerations of population, direct attention must be given to the size and numbers of employers in an area and the potential for marketing directly to a company or corporation rather than individual families.

Another objective requirement for successful development of a hospital based HMO rests with the availability of a nucleus of physicians with a strong interest to serve the membership of a prepaid group practice. The existence of professional opposition will have an immediate negative impact and will retard any rapid successful HMO development from the very start. Hostile professional actions are a part of the early history of HMO development. These actions varied in form from policy statements issued by medical societies warning physicians about the unethical nature of prepaid practice, to expulsion of HMO physicians from county medical societies thus challenging their very right of admission privileges. Changing times, attitudes, and federal legal involvement have reversed this trend, yet positive physician support must be present to make a new HMO succeed. This must be confirmed prior to initiation of plans.

In addition to an adequate population base and positive physician attitudes, good management and sufficient capital must be present to make the prepaid group practice a reality. In an existing hospital, the staff and equipment is already in place. Capital became less important with the existence of firm foundation to build on. The requirement is hospital management support to achieve the efficiency that an HMO-like potential has to offer in the existing hospital environment. Management then becomes the key. The development of benefit plans attractive to employers and family, recruitment of physicians, marketing of the program, establishing goals and evaluating performance become the prime ingredient in the formulation of a successful hospital based HMO.

Other considerations must be evaluated for success, but are of less importance. The legal barriers caused by state laws must be research by competent attorneys familiar with HMO organization and development.

One frequent cause of HMO developmental failure is insufficient commitment of sponsoring organizations in a community whether this be a hospital, a medical school, a medical group practice, or a community organization. The term insufficient commitment describes a circumstance in which there is not complete involvement or engagement of the sponsoring organization in the goal of achieveing an operational HMO. Commitment seems to take two perspectives consisting of adequacy and appropriateness. Development of an HMO is not easy and the sponsor's commitment must be equal to that task. From the standpoint of appropriateness, the objectives

of the sponsors must concurrently the same objectives that the HMO is capable of accomplishing. The creation of an HMO cannot solve such problems as individual inadequate incomes to purchase health care or the problem of insufficient physicians in an area to serve the HMO.

Another requirement for successful creation of an HMO is the availability of an adequate facility to provide comprehensive medical care. In many instances, an enterprising sponsor has sought out an aged building, a warehouse, a vacated grocery store, then refurbished it to satisfy the configuration and space needs of the HMO. This process is costly. Renovations, major construction, architectural expenses, furnishings, and medical equipment are extremely expensive initial outlays of capital. These expenses are before the first patient is even seen. Conversely, the development of an HMO is an existing hospital facility with it's existing equipment, furnishings, organization, and trained staff is not only logical, but the least costly in terms of initial capital expenditures. However, for manyoof the reasons outlined above, hospitals have not been the vanguard of the HMO movement. A combination of professional lack of financial interest and perceived threat to the management of hospitals based on future sustained low bed occupancy appears to be the primary cause for disinterest. Another major cause of infrequent hospital based HMO development is simple ignorance in that people do not understand what an HMO is or what it does. The development of an HMO-like operation in an existing hospital increases the already prevalent advantages of

accessibility, availability, continuity, efficiency, and economic quality care to the patient customer. Preventive care, health assessments, and complete medical record exist in a hospital now and become the foundation of any hospital-based HMO in the future. Multiple studies have concluded that statistics revealing the ever increasing use of hospital based ambulatory care are evidence of the popularity of the hospital as the primary treatment center for families. The staff of the hospital outpatient department and its emergency room have become the family physician to many individual.[15] The system of treatment referrals, admissions, and management of the patient in this environment exists in both HMO's and hospitals in general. Not only has the patient been coming to the outpatient clinic and emergency room more that the private doctors office, but also the physician has been leaning toward a trend of hospital association and group practice. Today's physician and administrator are beginning to realize that most medicine in ambulatory care oriented, and that the most efficient and economically advantageous way to practice this type of medicine is in a group setting.

The establishment of a hospital-based HMO under the criteria mentioned above requires a minimum of capital investment, provide excellent care for the enrolled members, and provides stability and economic rewards for member physicians. The health care system is involving slowly, impacted by social, technological, educational, economic, and governmental pressures that cause many hospitals to find themselves in financial difficulties. Many of these financial problems

were nonexistent in the past, but with the evolution of time, situations change causing some hospitals to face disasterous financial situations.

Federal Agency Interaction

For several months in 1977, informal discussions had been ongoing between members of the Division of Health Maintenance Organizations and the Director, Division of Facilities Development, Mr. Sam Gilmer, Jr. The focus of these discussions centered on the potentials of hospital-based HMO development. Mr. Gilmer's division is responsible to monitor the residual activities of the guarantee loan program of the old Hill-Burton Program that is now consolidated within the configuration of P.L. 93-641.

The development of HMO's within hospitals in the past has met with marginal success. As of August 1977, a census of HMO prepaid plans was conducted by a coalition of the Group Health Association of America, Inc., American Association of Foundations for Medical Care, Blue Cross Association, Health Insurance Association of America, and the National Association of Blue Shield Plans. The purpose of this study was to bring consistency to a current census of HMO development and include such data in a central document. Data was acquired on all existing HMO-like organizations in existence. The data revealed 165 active prepaid group practices functioning throughout the United States. These HMO's were sponsored by a combination of physicians, insurance carriers, universities - state or local government, consumer groups, labor groups, and hospitals. The census indicated that only 5 of 165 HMO's were sponsored by hospitals. This figure represents only

three percent of all sponsoring HMO activities could be found to rest completely with hospitals.[16]

The continuing discussions between federal leaders managing HMO and DFD operations recognized this phenomenon and each addressed the problem. Both agencies of the federal government were of the unanimous opinion that cooperative actions between the two agencies could have good benefits for both programs and for health care provided in certain communities. The staff of the Division of Facilities Development (DFD) was particularly interested in those hospitals who were experiencing financial difficulties in repaying federally guaranteed loans which had been issued by DFD for the construction or modernization of community hospitals. Both agencies were, for the first time, interested in working with one another to identify potential existing hospital sites where HMO development might provide an infusion of revenue to resolve current financial problems. These hospitals, with their existing physical plants, might be a viable source of HMO development because of the reduced requirement for large capital investments in existing areas such as X-ray, laboratory, and office space. If potential hospitals could be identified from existing Hill-Burton files that provided possible HMO successes, a new coordinated effort between two federal agencies would be a rewarding program benefiting hospitals, communities, and the government's investment in failing medical facilities. The identification of hospitals with

potential loan defaults were of primary consideration to DFD. This factor encouraged their cooperation and contribution to continued discussions.

Site Identification

A review of the entire files of the Division of Facilities Development was conducted searching for hospitals who were pending loan defaults. Once acquired, each hospital was reviewed with consideration being given to the factors of success required for the development of an HMO.

Cochise Hospital, Douglas, Arizona

In 1973, Cochise Hospital, Douglas, Arizona, applied for a Hill-Burton guaranteed loan in the amount of $1,983,000. This loan was to be used to construct and replace existing hospital beds in a structure which had been in operation since 1910. Additionally, the loan was to replace existing ancillary-professional areas and administrative areas. The goal of this guaranteed loan from the government was to construct and remodel Cochise Hospital to contain 75 short term and 50 long term beds. The need for this loan for remodelling and construction is of interest to the problem.

Background

Douglas, Arizona, is primarily a medium size industrial community

with emphasis on mining. One large employer is the Phelps-Dodge corporation who, until 1973, had owned and operated their own hospital, Douglas Hospital, primarily for the health care needs of their employees. Licensed by the Arizona Department of Health, this hospital operated 35 beds. It also provided hospital services to the entire community of 17,000. In 1973, the Phelps-Dodge Corporation applied for a Certificate of Public Need to permit closure of their institution, requesting that Cochise Hospital absorb their patient load.

Cochise Hospital, located approximately six miles from Douglas Hospital, is operated under the auspices of the Cochise County Hospital Association, an Arizona non-profit corporation. Cochise Hospital's occupancy rate was low enough to absorb the patients from the closing Douglas Hospital. Cochise Hospital had a physical plant with capacity for 132 beds, 82 of these short-term acute patients and 50 for longer term patients. Thirty six of the long-term care beds were certified for extended care and 14 were used for minimal nursing care.

The Phelps-Dodge Corporation was closing their old hospital because it was simply too expensive to maintain. Other hospitals had been developed in the area and the competition was becoming financially a corporate problem. In addition to Cochise Hospital, the county contained four other hospitals located at Bisbee (52 beds), Benson (25 beds), Sierra Vista (52 beds), and Wilcox (25 beds). Cochise Hospital was

capable of providing service to the Phelps-Dodge Corporation's population in a more efficient manner then was presently possible because of the duplication of many costly services in the two existing facilities.

Cochise Hospital applied for a Hill-Burton guaranteed loan recognizing the States Health Plan's restrictions as to bed allocations in the county as a whole. In consideration of the State Health Plan, Cochise requested funds to construct and remodel their hospital to ultimately contain 75 short-term beds and 50 long-term beds. Physician staff from the Douglas Hospital would be transferred to Cochise Hospital.

Financing of the loan was agreed to with the University of Texas Pension Fund as the loan source and plans were enacted to commence construction.

Cochise Hospital Problems

In July 1977, the federal government was notified by the University of Texas Pension Fund that Cochise Hospital was in default of their guaranteed loan by virtue of not having made any interest payments on construction drawdown costs and failure to make principle and interest payments.[17] Further correspondence between HEW and the University of Texas confirmed this delinquency and found that the loan holder had failed to adequately control their account for almost two years. Now

the University of Texas was requesting a large single payment which jeopardized the entire loan offering potential default.[18]

Since 1975, the Cochise Hospital management had deteriorated to the point where many bills were left unpaid and the financial condition of the hospital became progressively worse. The Hospital Association Board, its trustees, felt that the major cause of the financial problem was the contractual relationship the hospital had with the county. This was in the form of a ground lease agreement whereby Cochise County, Arizona, agreed to lease the land the hospital was constructed upon to the Hospital Association for a 25 year period provided the hospital provide care to indigent and other services at a fixed fee. The Hospital Association had also agreed to make monthly payments to the county as part of this lease agreement for related facilities.

In July 1977, the Hospital Association Board of Trustees notified Cochise County that it was relinguishing operation of Cochise Hospital. This action placed the Association in violation of the ground lease and the county now assumed full operational responsibility for the hospital. The Hospital Association, as a parting action, engaged the services of a bankruptcy attorney to undertake the filing of bankruptcy action. The Board of Trustees felt that by ceasing operations and wiping out all existing current operations it would clean the slate for new management to assume operation of the facility.

The perception that the land lease agreement between the Hospital Association and the county was the cause of the problem is questionable. A more detailed examination of the financial situation reveals that the hospital lacked financial controls and adequate cash management. Example of this absence of financial management was that no action had been taken by hospital management to insure prompt payment or collection of accounts receivables from third party payors. Furthermore, no effort had been made to secure payment of accounts receivables for services to even those other than third party recipients.

Two other areas of financial management abuse are evident from a review of records. During the period 1973 through 1977, the Board of Trustees of the Hospital Association agreed to take over and direct the operations of another hospital, Bisbee-Phelps Dodge, located in Bisbee, Arizona. In the course of this action, the association assumed $100,000 in obligations for which it received insignificant reimbursement. Furthermore, Cochise Hospital's physical plant valuation was listed at only $2,000,000, whereas the actual worth had been estimated at $8,000,000. If management had taken appropriate action to readjust the plant evaluation upwards to the current and realistic value, Cochise Hospital could have been receiving substantial increased reimbursement from Medicare and Blue Cross. This factor is based upon depreciation of the physical plant and the impact on adjustments in the formula for reimbursement considered by these third party payors.

When the Board of Trustees of the Association realized the extent of their financial situation in March 1977, action was taken to replace the hospital administrator with a management firm. The management firm, National Medical Enterprises, began operation of the firm in May 1977. As noted earlier, in July 1977, the Hospital Association Board of Trustees relinquished operation of Cochise Hospital to the Cochise County Board of Supervisors. The Board of Trustees has ceased to function and the County Board of Supervisors openly admits it does not want to operate the facility because of the continual cash drain to the county. Operation of Cochise Hospital is being financed from county general operating funds.

Traditional Alternatives

Of immediate concern to the staff of the Division of Facilities Development was protection of the government's interest. The delinquency in notes payable to the University of Texas Pension Fund placed the guaranteed government loan in close default. Courses of actions open to the government varied markedly as reflected in a letter from the Regional Health Administrator to the Director, Division of Facilities Development. Comments in regards to this crisis left many possible paths to follow, some of which are reflected below:[19]

1. Pay off the entire loan and operate through a contractor until the government can arrange a sale.

2. Bring the current loan principal and interest current and continue to operate on a contractual basis.

3. File an injunction to prevent the Cochise Hospital Association from filing bankruptcy action and bring suit against the Association on the basis of the performance of their lease.

4. Cure the defect in the current lease by HEW operation of the hospital until total repayment is affected.

5. Allow the Hospital Association to file bankruptcy and develop a new Board to operate the hospital.

The suggested traditional alternatives proposed above are not all inclusive. They are but the components necessary to salvage this hospital utilizing traditional means. Other perspectives are demanded in an era of debate concerning cost containment, alternatives to health care, and equality of access to health services.

Footnotes

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19. United States Government Memorandum, from Sheridan L. Weinstein, Region IX Health Administrator, USPHS, to Sam Gilmer, Jr., Director, Division of Facilities Development, USPHS, dated 22 September 1977.

Chapter IV

COMBINED PROGRAMS AND NEW DIRECTION

Overcoming Barriers to Joint Federal Action

Hospitals, much like Cochise Hospital, are the primary providers of health care services in any community and their positions must be preserved and strengthened economically if they are to continue to provide quality services. A colaborative arrangement between interested governmental agencies can offer a prescription for the malady of financial distressed health care facilities if only a consorted effort on the part of all is achieved. Communication is the key. Commercial interest are not to be left out, for here rests the potential sponsorship that can be the ultimate success or failure of sustained development of a prepaid health care system.

The successful mergence of federal agency involvement offers potential opportunities for HMO growth in areas not yet touched by developmental action. The federal government is vast and this characteristic retards communication and tends to build barriers around agencies which insulate one from the other. Each respects or ignores the others function to the point where suggested partnership in a project is considered a territorial attack or an overt attempt to gain a financial advantage for future budget determinations. Coordinated effort in the public health sector is not guiltless of this criticism.

Compounding this issue is the power exhibited by special interest

groups who lobby diligently in attempts to satisfy their constituents, each who seek self preservation of their individual goals and objectives. Entities such as the American Medical Association and the American Hospital Association , although characterized as benevolent benefactor of society's health needs, are frequently the villain in the complex plot which deters change and prevents advancement of new ideas that could benefit the health care system.

Throughout the years until just recently, the American Medical Society opposed the concept of Health Maintenance Organizations. Strong opposition had been registered in publications and the press by an able and vocal public relations campaign which attacked every advantage voiced by advocates of this emerging alternative health care delivery system.[1] The attack rendered by this power lobby group covered all aspects of the design of prepaid health activities and was based upon the threat that prepaid group practice imposed on the traditional fee-for-services establishment.

The American Hospital Association in the past also was not neutral on HMO development. With the provider at risk in an HMO, incentives were built into the prepaid organization to deliver only necessary services, much of which was conducted on an outpatient basis. The capitation system provided comprehensive care to HMO enrollees at a pre-determined fixed monthly fee. The incentives of such financial organizations predicted fewer elective surgeries, lower hospitalization rates, and less costly treatment regimes for their members. Hospitals were threatened

by this challenge to their future revenue.[2]

With the federal government's pressure to support cost containment in the health care area, both the AMA and the AHA's position have become more flexible toward HMO growth. The Board of Trustees of the American Medical Association established an independent commission on the cost of Medical Care in 1977. The commission was composed of 27 members, drawn from a broad base of expertise, represented the AMA, AHA, Blue Shield, Blue Cross, government, insurance companies, educators, and independent study groups. The results of their evaluation of the health care system formally indorsed Health Maintenance Organizations.[3]

With the insurgence of national pressures to control the cost of health care, and Federal Trade Commission and Department of Justice involvement in constant inquiries in AMA and possible AHA deterents to practices effecting competition, the strong positions of these two lobbies was softened. The effect of an ever increasing neutral position on the part of these two important groups and the strengthened emphasis of the federal government to reduce health costs favored future government agency interaction towards this goal.

Cochise Hospital's plight, as described above, offered an opportunity for coorperative effort by completely separate government agencies. A catalyst was necessary. This catalyst could be the desire to salvage the government's guaranteed loan and the administration's desire to further developments of HMOs. If with these goals a common meeting place could be found, developmental potentials could result.

Combined with the two catalysts mentioned was the softer positions being taken by the AMA and the AHA on prepaid group plan development. The administration's position was strongly in favor of coordinated efforts and two major government watchdog agencies, the Justice Department and the Federal Trade Commission, were making threatening gestures toward all activities and power groups who infringed on competition in the health care arena.

Cochise Hospital represents a potential site of multi-agency involvement. This involvement includes the resources available to the federal government, state and local government, community and business interests and individual consumer groups.

Cochise Hospital is not unique. Many other facilities are under financial attack as the result of inflationary evolution of our health care environment process.

The question of how Cochise Hospital or other hospitals in similar situations should be organized to provide sufficient revenue while still being cost effective and maintaining medically necessary services is a most complex problem. Perhaps the best solution is to overhaul the entire system.

From time to time, business and industry routinely reappraise their operations with a view of improved efficiency. Like business and industry, hospitals similar to Cochise Hospital must reappraise their individual operations. With the continued proliferation of hospitals, nursing homes, and other outpatient clinics and services expanding in communities similar to Douglas, Arizona, a hospital such as Cochise Hospital cannot sit idly by waiting for salvation. The principals of efficiency and effectiveness found in the business market place just cannot be expected to work in the health care arena.

Cochise Hospital is the primary provider of health care services in its community and it should be preserved and strengthened economically if it is to continue to provide quality services or exist at all. Reappraisal and reorganization requires a commitment to change. This change is not only for the sake of the hospital, but for the sake of the patients and community it serves.

Cochise Hospital is representative of other facilities plagued with underutilization, duplication, expensive services and facilities, uncoordinated capital planning, indigent patient care responsibilities, and common push-pull demands between certain health care disciplines where mutual cooperation should exist. Lack of coordination of all of the above is an expensive luxury to continue to live with.

Cochise Hospital is experiencing real economic concerns. Decreased or low occupancy at 17 percentage points below that anticipated for repayment of the guaranteed loan is a decided factor in the loss of patient revenue.[4] Nevertheless, Cochise Hospital and others like it have an opportunity to take a leadership role in reorganizing and reappraising its circumstance.

Empty beds and unused space are expensive commodities. The community as a whole is being done a disservice when it is required to pay for this unneeded bed and space. Reappraisal of the traditional mode of operation is required to determine if and how unnecessary beds and unused space can be converted into revenue producing services.

In this respect expansion and diversification could provide a potential economic answer. Present services can be expanded and marketed on an outpatient basis. Diversification, the provision of new services, could also provide new additional revenue. Unused beds

could be converted into long term care and rehabilitation areas. Unused beds or existing space could be used for new services, professional offices, or even leased to produce income.

The key to diversification and expansion is change to maximize resources to provide needed community services. In addition to providing those inpatient, outpatient, and subacute facilities that are being demanded more and more today, Cochise Hospital's financial position may be strengthened by initiating other ventures or services that may not be directly related to patient care but which utilize the hospital's existing resources.

Cochise Hospital as a Hospital Based HMO

Industrial Support

Cochise Hospital appears to be in an excellent situation for the development of an HMO. The Phelps-Dodge Corporation, through its own economic concern, has closed its own hospital facility due to the present duplication of expensive facilities. It's action to close Douglas Hospital, a facility the corporation had managed for years, was not initiated with total disregard for the employees of its firm, but out of economic concerns. It has taken a social and economic reappraisal of its situation and found that it could close its' doors and Cochise Hospital could provide adequate and sufficient care to its employees. The Phelps-Dodge Corporation is an industry in a small community waiting for HMO

development.

A hospital based HMO at Cochise Hospital would provide comprehensive health care services to the employees of the Phelps-Dodge Corporation. HMOs are designed to keep people healthy, an advantageous characteristic to any employer. HMOs stress the importance of preventive services along with early diagnosis and treatment. HMO offers educational programs for improving employees individual health. All these characteristics are in the social and financial interest of that corporation.

Industrial support of an HMO in Douglas, Arizona is a necessary element of success in this community. Industrial support offers an element of immediate financial returns to a hospital based HMO in the form known monthly income to the hospital based upon employee subscription to the HMO program. Direct monthly income from the Phelps-Dodge Corporation allows an advantage to both the hospital and the business concern. Cochise Hospital's accounts receivables would be known in advance based upon employee population. The Phelps-Dodge Corporation also would have the advantage of being now able to budget in advance for health care rendered its employees as opposed to the previous difficult method of dealing with the multiple unknowns of operating its own hospital.

A hospital based HMO in support of the Phelps-Dodge Corporation can offer that company's employees the efficiency of a unified,

comprehensive, single point of entry health care system. This quality is similar to the company's previous situation at their own hospital, but at reduced costs. Yet, the HMO has no incentive for unnecessary treatments, thus reducing excessive costs to the corporation. Dollars are to be saved by the Phelps-Dodge involvement in a hospital based HMO at Cochise Hospital. They will be able to negotiate a benefit package to their employees that will be satisfactory to all concerned. Not only will the employees be given a health care benefit package that is comprehensive in nature, but the Phelps-Dodge Corporation will know its costs in advance and also have the satisfaction of knowing that reduced hospitalization and increased preventive care will keep more employees on the job and not confined to a hospital bed. The illness that does not occur cost nothing.

Through the industrial support of a hospital based HMO at Cochise Hospital, the Phelps-Dodge Corporation would be practicing good business. Increased preventive programs, accident prevention, cardio-vascular screening, health education would all occur as a result of its development. As a business citizen, the company could involve itself in local health planning decisions, thus discouraging excessive capacity in other unneeded health ventures in the community.

Runaway health cost were the reason the Phelps-Dodge Corporation closed its Douglas Hospital. With this closure, the incentive exists

to support a new, cost-effective, prepaid group health plan at the adjacent Cochise Hospital. This action is in the interest of its own business, its employees, and the community.

Medical Support

For a hospital based HMO to be successful, the community of physicians must be acceptable to its concept and be an integral part of its future development. The sponsoring agent, be it Cochise Hospital, a major employer, or the community, must stress the advantages to be accrued to those physicians not familiar with prepaid practice organizations.

The physician who chooses to work for a prepaid hospital based HMO is spared the responsibility and expenses with establishing and running his own private practice. Cochise Hospital itself would provide the office space, equipment, and hire the support personnel to assist the physician. The doctor would not be concerned with administration, billings, insurance forms, or bad debts. As can be seen, very little capital investment would be required, if any, to entice physicians into such an arrangement.

One of the most sellable advantages to physicians would be regular working hours. The physicians in a hospital based HMO would enjoy limited and known on-call responsibilities and vacations with adequate patient

coverage. In addition, other fringe benefits usually include malpractice insurance, their own medical and life insurance and a formal retirement program.

Regular continuing education programs are normally advanced as an inducement to joining physicians, whereby scheduled, regular non-patient time is set aside for doctors to stay current in recent advances in their chosen specialty. The ready availability of other physicians with which to share problems also is an attractive factor for physicians because it contributes to higher standards of care and better utilization of skills.

The attitude of the Cochise County physician is acceptable to HMO development and the advantages cited above are a further inducement for creation of a hospital based affiliation at Cochise Hospital.[5] HMOs are not unknown in Arizona, with three large HMOs currently successfully existing within the state. With the closure of the Phelps-Dodge Douglas Hospital, it is to be remember that the staff at this facility was essentially transferred to Cochise Hospital to absorb the additional new patient load.

One of the most important aspects in the formation of a medical staff for an HMO is to acquire the services and leadership of one respected and

admired physician to serve as Medical Director. The acquisition of such a prominent leader is the catalyst in the recruitment and retention of other physicians in the immediate area. This factor can also have a favorable impact on the HMO's relationship with business and community groups, while simultaneously attracting patient members to the HMO.[6]

Community medical staff support to the formulation of a hospital based HMO at Cochise Hospital appears favorable. Professional sanctions have been greatly reduced, especially in the West as a result of the success of the Kaiser Foundation Health Plans found in California, Colorado, and Oregon. Little social upheaval is predicted and physician acquisition is favorable.

Hospital Support

For Cochise Hospital, HMO affiliation or starting an HMO itself may be one method of survival. Although an HMO does reduce hospitalization, it can attract a large number of patients. Furthermore, striving to meet certain federal requirements will gain considerable financial support and also insure continued eligibility for Medicare and Medicaid reimbursements.

Cochise Hospital is at a tremendous advantage regarding initiation of a hospital based HMO. It has an established plant, furnished and with

adequate equipment. Its staff is in place, trained, and familiar with operating procedures. Minimal capital investment is required to establish an HMO, resulting in little if any pay back time on set-up expenditures for HMO organizational initiation. It has an organized outpatient clinic which can be quickly adapted to minor changes required by an HMO environment. Its current outpatient facilities consist of: pharmacy, radiology, ECG, inhalation therapy, psychiatric emergency services, an emergency service, occupational therapy, a social work department, and an organized outpatient department.

The hospital must be prepared to expand some services and diversify to provide some additional economic solutions to their problem. Utilizing existing resources within the hospital and strengthening unused beds and space in the facility may provide additional important revenue to make up for decreased bed utilization from HMO involvement. The initiation of new ventures and services may prove beneficial as revenue producing work centers.

Additional Revenue Programs

Suffice to say that the creation of a viable hospital based HMO will capture a source of income not previously generated by the hospital. However, the hospital will continue to support non-enrolled patient populations in the proximity of Douglas, Arizona, and other revenue

producing clinics could be easily developed internally to generate income. These new clinics would be an additional inducement to enroll new HMO customers or be income producing clinics for non-members utilizing such services. Such services could include drug and alcohol clinics; outpatient and home dialysis clinics; hospital supervised home health care clinics; health education clinics; and mental health clinics; and obesity clinics. Services such as these are not expensive additions and could be implemented with a small increase in present staff if space and time management were given close considerations.

The emergency department could expand and provide an area wide ambulance services. For a fee it could train ambulance drivers, firemen, and rescue workers. The emergency department could pursue and obtain a contractual relationship with the city of Douglas, Cochise County, or industrial entities for ambulance and emergency services on a monthly basis. All such items are not remote possibilities for hospital participation and possess potential revenue sources that can assist in solving critical cash flow problems.

Other, more imaginative programs are possible that can contribute to a reversal of a negative cash flow situation if managed properly. The on-site resources of an acute care hospital are varied. Usually, they are put to restricted use. A change in this pattern or a reversal from the traditional offers significant revenue producing concepts

that will aide and benefit Cochise Hospital or most hospitals to overcome financial difficulties. Some programs or alternatives consist of:

1. Rent unused office space.
2. Rent unused bed space.
3. Establish and market health educational programs for doctors offices and nursing homes.
4. Initiate a physicians answering service.
5. Utilizing hospital food service personnel and equipment, sell or contract food service to the local jail, prison, nursing homes, and initiated a meal on wheels to the working community.
6. Expand and diversify the contractual arrangements in the hospital with talents/equipment of its central purchasing and laundry by contracting it out to other commercial firms in need of its resources.
7. Sell the services of the hospital's radiology, laboratory and pharmacy to both medical and non-medical firms in need of related services. This could be the local veterinarian for drugs, lab and radiology services or another hospital or doctors office in need of related services.
8. The hospital, utilizing its HMO staff, could provide technical and professional consulting services to other institutions or large business firms.
9. The potential exists to contract with local schools to provide such needed care as dietary consultations or speech therapy and/or

occupational therapy contracts with local industries for their non-HMO employees.

10. Existing unused hospital space could be converted into productive and less expensive long-term care areas or rehabilitative treatment centers. This not only adds needed revenue, but reduces plant costs for local, state, and national accreditation requirements.

11. The hospital could contract to manage other hospitals, nursing homes, neighborhood health clinics or any other programs providing health care.

As can be seen from the above alternatives, departure from the traditional offers financial rewards that few hospitals of today seek or acknowledge as possible.

In order to pursue both HMO development and alternative revenue producing mechanisms, considerable planning is required. This planning entails joint action and cooperation of the hospital's governing body, its providers, managers, and possibly major employers in the area. Planning will require a study group and some advantage could be gained by establishing this study group as a non-profit legal entity under 501 (c) (3) in a tax exempt status. This action would entitle the group to seek and solicit outside funds to support and finance the foundations of the groups initial programs.

Footnotes

1. Van Note, Peter. "HMO Program: 1970-1976," a review prepared by the American Medical Association News Bureau, June 1977.

2. Hardy, Crawford R. "Contracting with HMOs", Hospital Financial Management: (August 1976): 10.

3. "National Commission on the Cost of Medical Care - Summary Report", American Medical Association News Release, December 1977. To be published.

4. Cochise Hospital Association, Financial Statement for the Month of June 1977 compared to application for Hill-Burton Loan, Project #126MOD/NC for Cochise Hospital, 11 June 1973.

5. Interview with George Courie, MD, Medical Officer, Division of Health Maintenance Organization, Department of Health, Education, and Welfare conducted in Rockville, Maryland, 10 March 1978.

6. Ibid.

Conclusions and Recommendations

Government intervention in the Douglas, Arizona salvation regarding Cochise Hospital is inevitable. It will vary from bringing the payments currently on the existing loan with the University of Texas, to paying off the entire obligation of $1,900,000. The short term financial interests of the government appears to be paramount in all discussions. Little is mentioned of the services provided to the health care needs of the community. Nevertheless, coordinated actions between government agencies is a distinct potential course of action to resolve the financial situation on a long term basis. Until the University of Texas Pension Fund, the mortgagee, forwards a demand letter, the government's loan and the hospital's services are not in jeopardy. However, once a demand is placed upon the hospital, the government is forced to act. Possible courses of action in the short term appear to be an injunction against the Hospital Association Board of Trustees from pursuing bankruptcy, an immediate audit of all hospital accounting records, and work out arrangements with the University of Texas on past due credit based upon independent audit findings. This arrangement hopefully would bring the mortgagee's demands current and provide time for a management contract to be renewed for continued hospital operation.

Leverage placed upon the Hospital Association by the Division of Facilities Development would allow a coordinated effort by the Division of Health Maintenance Organization and the time to pursue discissions with

the Cochise County supervisors, community leaders, providers, and business firms regarding the advantages of HMO involvement in a hospital based environment.

Advantages to be gained from this joint venture have been stated earlier. The financial crisis experienced by Cochise Hospital offers the opportunity to temporarily satisfy current problems and work towards the future, developing a management strategy to bring the hospital to a sound financial base. Prepaid group practice in a hospital based environment can be achieved with a minimum of capital investments at Cochise Hospital. The environment is conducive to success. Marketing of HMO benefit packages to employers with large populations such as found in the environs of Douglas, Arizona, is a secure and efficient method of obtaining quick membership and future success.

If the federal government is prepared to commit itself to the development of alternatives to the nations' health care delivery system, successful achievement of a hospital based HMO at Cochise Hospital is a distinct potential for success. Utilizing innovative revenue producing centers within the hospital, the hospital of today must achieve some degree of success marketing a product to its consumers. These consumers need not fall in the traditional catagory of in or outpatient, but should be considered the community at large. The results will be a continuance

of the pluralistic health care system, a revitalization of private involvement, and reduced health care cost to the patient. Concurrently, the hospital survives and achieves growth, expansion, and diversification through change.

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